Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

CHEOR J KIM, MD
3100 TIMMONS LANE #250
HOUSTON, TX 77027

Respondent Name

METROPOLITAN TRANSIT AUTHORITY HARRIS CO

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-11-2134-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CARRIER REFUSES TO PAY THIS CLAIM FOR SERVICES RENDERED EVEN AFTER A REQUEST FOR RECONSIDERATION WAS SUBMITTED."

Amount in Dispute: $500.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The October 7, 2010 exam was set to address only MMI and impairment rating issues. The extent of the compensable injury had already been defined by prior designated doctor evaluations. Accordingly, it was inappropriate for the Requestor to conduct and bill for alternative MMI and IR determinations"

Response Submitted by: Flahive, Ogden & Latson, 504 Lavaca, Ste 1000, Austin, Texas 78701

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 07, 2010	99456-W5-WP and 99456-MI	$500.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services effective March 1, 2008.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated October 28, 2010
   - W1 – Workers Compensation State Fee Schedule Adjustment
   - 214 – Workers' Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment.
   - Comments: W1/214 – Per Dr. Kim's 1/18/10 DD report, which addresses extent of injury, the injury was determined to be a closed head injury and hydrocephalus post traumatic. The hydrocephalus post traumatic was determined to be not compensable per D&O dated 10/13/10. As such, the adjudicated injury is limited to a closed head injury. Multiple impairment ratings are not indicated in this case. Reimbursement is recommended for $350 for MMI and $150 for non-musculoskeletal body areas (head).

   Explanation of benefits dated November 29, 2010
   - W1 – Workers Compensation State Fee Schedule Adjustment
   - 193 – Original payment decision is being maintained. This claim was processed properly the first time.
   - 214 – Workers' Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment.
   - Comments: 193 – Reconsideration of ITN 00413903. Previous recommendations remains [sic] unchanged. 214 – Per Dr. Kim's 1/18/10 DD report, which addresses extent of injury, the injury was determined to be a closed head injury and hydrocephalus post traumatic. The adjudicated injury is limited to a closed head injury only. Multiple impairments are not indicated in this case. Reimbursement is recommended for $350 for MMI and $150 for non-musculoskeletal body areas (head).

Issues

1. What Designated Doctor (DD) services did the Division order?
2. Is the requestor entitled to reimbursement for disputed services under 28 Texas Administrative Code §134.204?

Findings

1. The Division order on the EES-14 form was to address Maximum Medical Improvement and Impairment Rating (MMI/IR) for the compensable injury only. The requestor (DD) has billed $950.00 for 3 units of CPT code 99456-W5-WP and $50.00 for CPT code 99456-MI. The DD is billing for compensable areas (closed head injury) and additional areas including lumbar and cervical (spinal region), left shoulder and elbow (upper extremity), as well as the knee (lower extremity). Documentation supports that MMI was assigned. Per 28 Texas Administrative Code §134.204(j)(3)(C), the Maximum Allowable Reimbursement (MAR) for MMI is $350.00. The IR per AMA Guides to the Evaluation of Permanent Impairment, 4th Edition for a non musculoskeletal area of closed head injury is per 28 Texas Administrative Code §134.204 (j)(4)(D)(iv) and (v) with a MAR of $150.00. At issue is the rating of additional body areas not eligible for payment. The extent of injury was established through a previous DD examination which was performed by the same health care provider.
2. The respondent has paid $350.00 for the assignment of MMI and $150.00 for an IR to the compensable injury for a total of $500.00. Therefore, the requestor is not entitled to any additional reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the disputed services.

Authorized Signature

Signature	Gregory Fournerat Medical Fee Dispute Resolution Officer	January 30, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**
Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.